

SOUTH DAKOTA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

116002

SCHOOL _____	DISTRICT _____	GRADE _____	YEAR _____
CHILD'S NAME _____		BIRTHDATE _____	
PARENTS' NAME _____		TELEPHONE _____	
PARENTS' ADDRESS _____		CITY, ZIP _____	COUNTY _____

VACCINE TYPE	ENTER DATE (mo/day/yr) EACH IMMUNIZATION WAS GIVEN				
	1st	2nd	3rd	4th	5th
DTP/DTaP/DT					
Td					
OPV/IPV					
MEASLES			OR DATE CHILD HAD DISEASE HISTORY OF DISEASE NOT ACCEPTABLE HISTORY OF DISEASE NOT ACCEPTABLE		
MUMPS					
RUBELLA					
Varicella (Chickenpox)			OR HISTORY OF DISEASE (Parental History Acceptable – requires parent or guardian signature) SIGNED _____ DATE _____ (Parent or Guardian)		
Hib					
Hepatitis A					
Hepatitis B					
Other					
Other					
TUBERCULIN TEST (Mantoux Recommended)		INDURATION (In mm): _____			

TO THE BEST OF MY KNOWLEDGE, THIS CHILD HAS RECEIVED THE ABOVE IMMUNIZATIONS AND TEST FOR TUBERCULOSIS.

SIGNED _____ DATE _____
(Physician, Nurse, School Health Authority or Department of Health Staff)

PRINTED SIGNATURE _____ ADDRESS OF CLINIC/FACILITY _____

MEDICAL EXEMPTION TO IMMUNIZATION LAW

The physical condition of the above named child is such that a test or immunization would endanger life or health.

Please check the appropriate box(es) if this statement is being signed:

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Polio ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella (Chickenpox) ☐ Tuberculosis

SIGNED _____ DATE _____
(Licensed Physician per SDCL Chapter 36-4)

PRINTED SIGNATURE _____ ADDRESS OF CLINIC/FACILITY _____

RELIGIOUS EXEMPTION TO IMMUNIZATION LAW

Parent or guardian of the above named child adheres to a religious doctrine whose teachings are opposed to such test and immunization.

SIGNED _____ DATE _____
(Parent or Guardian)